Tohono O'odham Nation
Division of Early Childhood Development
Head Start Application

STUDENT DOCUMENT TRACKING FORM

Child's Name: _____ Center/Home Based Area: _____

The following is a checklist to make sure all necessary forms and documents are in place and complete.

Documents Required for Enrollment: ***Please make sure you schedule a Dental Exam and Physical/Well Child Exam if they have not been updated within the current year. Printouts of current immunizations, Dental, and Physical/Well Child can be requested from the health facility by filling out a Release of Information form.***	**Date and Initial** **When all forms and documents are in place.**	**DOCUMENTS *STILL NEEDED***	**Notes/Comments for staff to document information.**
Application Form			
Birth Certificate-proof of age			
Income Verification Form			
Proof of Income			
Income Guideline Form			
Health Information			
Consent for Health Services Form			
Emergency Contact Form			
Guardianship Document (If applies)			
**Dental Exam*			
**Immunizations*			
**Physical Exam/Well Child*			
Tribal Enrollment Letter			
Insurance/AHCCCS			
IFSP (Individual Family Service Plan)			
IEP (Individual Education Plan)			
Social Security Card Verified			

Keep Original/Provide Copy to Parent/Guardian

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School Year 20____ - 20____

☐ **New** ☐ **Returning** ☐ **3rd Year** **Center/Home Based Area: _____**

Child's Name: _____

Date of Birth: _____ **Gender: _____**

Social Security Verified: ☐ **Yes** ☐ **No** **Primary Language Spoken:** ☐ **English** ☐ **O'odham** ☐ **Other: _____**

Insurance/AHCCCS: ☐ **Yes** ☐ **No** **Is child receiving services from WIC?** ☐ **Yes** ☐ **No**

Child's Race/Ethnicity: ☐ **Caucasian** ☐ **Hispanic/Latino** ☐ **Asian** ☐ **Hawaiian/other Pacific Islander** ☐ **African American**
☐ **American Indian/Alaskan Native** **Tribe: _____** **Enrollment Number: _____**

IF BOTH PARENTS ARE LISTED ON THE BIRTH CERTIFICATE, PLEASE FILL OUT BOTH SECTIONS BELOW

A. PRIMARY PARENT INFORMATION	**B. SECONDARY PARENT INFORMATION**
Name: _____	**Name:** _____
Gender: _____	**Gender:** _____
Relationship to child:	**Relationship to child:**
☐ Biological Parent ☐ Adoptive Parent ☐ Step Parent	☐ Biological Parent ☐ Adoptive Parent ☐ Step Parent
☐ Legal Guardian ☐ Foster Parent Other: _____	☐ Legal Guardian ☐ Foster Parent Other: _____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living with Partner	**Marital Status**: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living with Partner
Does the child live with the parent/guardian?	**Does the child live with the parent/guardian?**
☐ All of the time ☐ Some of the time ☐ No	☐ All of the time ☐ Some of the time ☐ No
Mailing Address: _____	**Mailing Address:** _____
Directions to your home: _____ _____	**Directions to your home:** _____ _____
Home Phone: _____	**Home Phone:** _____
Cell Phone: _____	**Cell Phone:** _____
Employer: _____	**Employer:** _____
Occupation: _____	**Occupation:** _____
Work Phone: _____	**Work Phone:** _____
Other: ☐ Unemployed ☐ Student ☐ Stay at home parent ☐ Disabled/Retired	**Other:** ☐ Unemployed ☐ Student ☐ Stay at home parent ☐ Disabled/Retired
Email Address: _____	**Email Address:** _____
Contact Person and Phone Number: _____	**Contact Person and Phone Number:** _____

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INCOME VERIFICATION FORM

Child's Name: _____ Center/Home Based Area: _____
☐Parent(s) ☐Guardian(s) Name: _____

Family members supported by income:	Relationship to Head Start Child:
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
Parent/Guardian's Income: ☐Yes ☐No	Secondary Parent/Guardian's Income: ☐Yes ☐No
Hours Per Pay Period: _____ OR Per Week: _____ Hourly Rate: _____ ☐Weekly ☐Biweekly ☐Monthly	Hours Per Pay Period: _____ OR Per Week: _____ Hourly Rate: _____ ☐Weekly ☐Biweekly ☐Monthly
At least one supportive document is attached: ☐Pay Check Stubs/W-2 Forms ☐ Written Statement of Self Employment/Unemployment ☐AFDC, SSI, GA, Student Stipend ☐Child Support ☐No/Zero Income ☐Last Year Income (Returning for a 2nd Year)	At least one supportive document is attached: ☐Pay Check Stubs/W-2 Forms ☐Written Statement of Self Employment/Unemployment ☐AFDC, SSI, GA, Student Stipend ☐Child Support ☐No/Zero Income ☐Last Year Income (Returning for a 2nd Year)

*******OFFICIAL USE ONLY*******

Proof of Calculations: _____ *(Coordinator/Admin Initial)*

☐*Monthly X 12(Applies to DES Statements)* ☐*Bi weekly X 26*

☐*Weekly X 52* ☐*School System X 19*

I have reviewed and certified the income documentation.

Total Annual Income: $_____ *Total in Household: _____* *Age of Child: _____*

Eligibility Status: ☐*Income Eligible* ☐*Over Income*

Head Start Program Manager's Signature*: _____** ***Date ____/____/____

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HEALTH INFORMATION

Child's Name: _____ Center/Home Based Area: _____

MEDICATIONS

Does your child take prescribed medication on a regular basis? If yes, list here:	☐ Yes ☐ No

ALLERGIES

Does your child have any diagnosed allergies to food? If yes, list here:	☐ Yes ☐ No
Does your child have any other diagnosed allergies? (Bees, ants, plants, latex, etc.) If yes, list here:	☐ Yes ☐ No
Does your child take prescribed medication for an allergic reaction? If yes, list here:	☐ Yes ☐ No

SPECIAL DIETS

Does your child need dietary accommodations for cultural, religious, or medical reasons? If yes, list here:	☐ Yes ☐ No

NUTRITION

Does your child experience any symptoms while and/or after eating? (Gagging, vomiting, etc.) If yes, list here:	☐ Yes ☐ No
Does your child eat any non-food items? (Glue, paint chips, erasers, dirt, etc.) If yes, list here:	☐ Yes ☐ No

CHRONIC ILLNESS/SPECIAL HEALTH NEEDS

Does your child have a diagnosed chronic illness? If yes, list here:	☐ Yes ☐ No
Does your child have any diagnosed special health needs? If yes, list here:	☐ Yes ☐ No

OTHER CONCERNS

Do you have any concerns with your child's speech, hearing, vision, or physical abilities? If yes, list here:	☐ Yes ☐ No

Use lines below should any yes questions need further explanation:

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CONSENT FOR HEALTH SERVICES

Child's Name: _____ Center/Home Based Area: _____

I/We understand:

1. It is my/our responsibility to provide Tohono O'odham Nation Head Start Program with a current dental examination, a current immunization record, and a current physical/well-child exam.
2. Head Start provides the following screenings to enrolled children within the school year:
   - Developmental Screening
   - Height and Weight Screening
   - Speech Screening
   - Vision Screening
   - Hearing Screening
3. In case of an emergency or if a parent/guardian cannot be contacted, the Tohono O'odham Nation Head Start Program may provide basic first aid or contact emergency services for care/transportation if needed.
4. Head Start can provide referral information to parents/guardians for Behavior/Mental Health services.
5. Head Start can provide transportation for services that are in support of the program.

If there are any special emergency instructions for your child please state them below:

_____

_____

I/We _____hereby give consent to all the Head Start screenings for my/our child to receive during the school year. I/We understand the support and limitations outlined in 1-5 that Head Start provides related to screenings, emergency situations, transportation and referrals.

☐Parent(s) ☐Guardian(s) Signature: _____Date ____/____/____

Head Start Staff Signature: _____ Date ____/____/____

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EMERGENCY CONTACT FORM
School Year 20____- 20____

Child's Name: _____ Center/Home Based Area: _____

To ensure the safety of your child/ren will NOT be released to ANYONE, who is not listed below, or is suspected of being under the influence of alcohol/drugs. It is the Parent/Guardian's responsibility to communicate with all authorized individuals about all information regarding child/ren pick up/drop off.

All individuals must be 18 years or older.

Print Name	Relationship to child	Phone Numbers *(work, home, cell)*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

The Head Start Staff will contact the authorized individuals listed above in such cases that I/We are not available. If for any reason contact information does change, it will be my/our responsibility to notify Head Start staff to update all information.

☐**Parent(s)** ☐**Guardian(s) Signature:** _____ **Date**____/____/____

Head Start Staff Signature: _____ **Date** ____/____/____